		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027490

Facility Name: Manorcare at Kankakee

Address: 900 West River Place (Number) Kankakee (City) 60901 (Zip Code)

County: Kankakee

Telephone Number: (815) 966-1711 **Fax #** (815) 933-2065

HFS ID Number: 520886946003

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2004 to 05/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,055	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,347	7,360	9,879	34,586	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,347	7,360	9,879	34,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.56%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 107 and days of care provided 6,546

Medicare Intermediary CareFirst of Maryland, Ind.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Kankakee # 0027490 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	175,994	10,930	7,573	194,497	1,576	196,073		196,073			1
2	Food Purchase		135,957		135,957		135,957	(1,077)	134,880			2
3	Housekeeping	75,872	13,045	270	89,187		89,187		89,187			3
4	Laundry	38,037	12,723	1,269	52,029		52,029	(3,868)	48,161			4
5	Heat and Other Utilities			104,899	104,899	3,635	108,534	(4,534)	104,000			5
6	Maintenance	35,424	71,923	36,343	143,690		143,690		143,690			6
7	Other (specify):* **Med. Waste**			1,204	1,204		1,204		1,204			7
8	**TOTAL General Services**	325,327	244,578	151,558	721,463	5,211	726,674	(9,479)	717,195			8
	B. Health Care and Programs											
9	Medical Director			7,700	7,700		7,700		7,700			9
10	Nursing and Medical Records	1,566,396	130,949	11,830	1,709,175	26,879	1,736,054	(2,652)	1,733,402			10
10a	Therapy	126,329	16,285	115,217	257,831		257,831		257,831			10a
11	Activities	61,716	2,747	3,401	67,864		67,864		67,864			11
12	Social Services	72,379			72,379		72,379		72,379			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,826,820	149,981	138,148	2,114,949	26,879	2,141,828	(2,652)	2,139,176			16
	C. General Administration											
17	Administrative	64,315		272,572	336,887	(129,061)	207,826		207,826			17
18	Directors Fees											18
19	Professional Services			1,420	1,420	(660)	760	(760)				19
20	Dues, Fees, Subscriptions & Promotions			50,853	50,853		50,853	(24,453)	26,400			20
21	Clerical & General Office Expenses	120,817	34,184	54,098	209,099	660	209,759	(46,601)	163,158			21
22	Employee Benefits & Payroll Taxes			446,586	446,586	24,711	471,297		471,297			22
23	Inservice Training & Education			2,778	2,778		2,778		2,778			23
24	Travel and Seminar			6,972	6,972		6,972		6,972			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			106,609	106,609		106,609		106,609			26
27	Other (specify):* **P/S Admin**			(2)	(2)		(2)		(2)			27
28	**TOTAL General Administration**	185,132	34,184	941,886	1,161,202	(104,350)	1,056,852	(71,814)	985,038			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,337,279	428,743	1,231,592	3,997,614	(72,260)	3,925,354	(83,945)	3,841,409			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Kankakee #0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			186,507	186,507	10,748	197,255		197,255			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					61,512	61,512		61,512			32
33	Real Estate Taxes			46,121	46,121		46,121	(2,994)	43,127			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,081	18,081		18,081		18,081			35
36	Other (specify):*											36
37	**TOTAL Ownership**			250,709	250,709	72,260	322,969	(2,994)	319,975			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		196,720		196,720		196,720		196,720			39
40	Barber and Beauty Shops		383	6,757	7,140		7,140		7,140			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,584	58,584		58,584		58,584			42
43	Other (specify):* **See Schedule**		26,546	20,360	46,906		46,906		46,906			43
44	**TOTAL Special Cost Centers**		223,649	85,701	309,350		309,350		309,350			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,337,279	652,392	1,568,002	4,557,673		4,557,673	(86,939)	4,470,734			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (2,787)	21	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,077)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,534)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,868)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,652)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(760)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,246)	21		24
25	Fund Raising, Advertising and Promotional	(24,453)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,994)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,568)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (86,939)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (86,939)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare at Kankakee

ID# 0027490

Report Period Beginning: 06/01/2004

Ending: 05/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (3,123)	21	1
2	Donations Revenue	(445)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,568)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Kankakee # 0027490 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,077)	0	0	0	0	0	0	0	0	0	0	(1,077)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,868)	0	0	0	0	0	0	0	0	0	0	(3,868)	4
5	Heat and Other Utilities	(4,534)	0	0	0	0	0	0	0	0	0	0	(4,534)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,479)	0	0	0	0	0	0	0	0	0	0	(9,479)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,652)	0	0	0	0	0	0	0	0	0	0	(2,652)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,652)	0	0	0	0	0	0	0	0	0	0	(2,652)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(760)	0	0	0	0	0	0	0	0	0	0	(760)	19
20	Fees, Subscriptions & Promotions	(24,453)	0	0	0	0	0	0	0	0	0	0	(24,453)	20
21	Clerical & General Office Expenses	(46,601)	0	0	0	0	0	0	0	0	0	0	(46,601)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(71,814)	0	0	0	0	0	0	0	0	0	0	(71,814)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,945)	0	0	0	0	0	0	0	0	0	0	(83,945)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Kankakee** **#** **0027490** **Report Period Beginning:** **06/01/2004** **Ending:** **05/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(2,994)	0	0	0	0	0	0	0	0	0	0	(2,994)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,994)	0	0	0	0	0	0	0	0	0	0	(2,994)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(86,939)	0	0	0	0	0	0	0	0	0	0	(86,939)	45

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp.	Toledo, Ohio			
		of America				
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See	Home Office Cost	$ 272,572	HCR ManorCare, Inc.	100.00%	$ 272,572	$	1
2	V		Page							2
3	V		8							3
4	V									4
5	V									5
6	V		10a	Therapy Management	11,042	Heartland Management Services	100.00%	11,042		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 283,614			$ 283,614	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 5/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: ((419) - 252-5500
Fax Number: ((419) - 252-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	$ 0	$	4,273,767	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	4,273,767	1,576	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		4,273,767	404	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		4,273,767	3,231	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	4,273,767	23,477	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	4,273,767	3,402	6
7	17	General & Administrative - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	4,273,767	30,028	7
8	17	General & Administrative - Poole	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	4,273,767	113,481	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		4,273,767	7,094	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		4,273,767	17,617	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.			4,273,767	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		4,273,767	10,748	12
13										13
14	32	Interest				10,002,527			61,512	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 272,570	25

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub Debentures		X	Facility			$ 844,222	$ 844,222			$ 61,512	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 844,222	$ 844,222			$ 61,512	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 844,222	$ 844,222			$ 61,512	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Kankakee **#** 0027490 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	2,994	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,994)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,121	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,127	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	45,754	8
2001	46,753	9
2002	71,033	10
2003	48,654	11
2004	46,121	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Kankakee COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0027490

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) - 252-5740 FAX #: (419) - 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-09-31-412-001	See Attached	$ 23,060.58	$ 23,060.58
2.	16-09-31-412-001	See Attached	$ 23,060.58	$ 23,060.58
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,121.16	$ 46,121.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,938 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 29,077	1
2					2
3	TOTALS			$ 29,077	3

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88			1969	$ 566,769	$ 2,350		$ 2,350	$	$ 895,614	4
5	9			1988	533,782						5
6	10			1990	60,931						6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					105,557		105,557		1,349,622	9
10				1980	14,866						10
11				1981	90,159						11
12				1982	16,908						12
13				1983	11,723						13
14				1985	33,632						14
15				1987	56,199						15
16	RETIREMENTS			1987	(30,337)						16
17				1988	65,707						17
18				1989	92,574						18
19				1990	34,128						19
20				1991	13,615						20
21				1992	46,361						21
22	RETIREMENTS			1992	(5,120)						22
23				1993	359,644						23
24				1994	26,647						24
25				1995	85,884						25
26				1996	4,830						26
27				1996	2,444						27
28				1996	2,647						28
29				1996	7,272						29
30	C/R 5/31/99 AUDIT ADJ 1a - CAPITALIZED LABOR			1996	(7,272)						30
31				1996	6,000						31
32				1996	2,362						32
33				1996	3,921						33
34				1996	26,843						34
35				1996	1,104						35
36				1996	2,793						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		1996	$ 11,690	$		$	$	$	37
38	PLUMBING/SPRINKLER SYSTEM	1996	7,061						38
39	EMERGENCY POWER UPGRADE	1996	3,860						39
40	CARPET/WALLCOVERINGS	1996	1,730						40
41	NURSE CALL SYSTEM	1996	2,295						41
42	DECKING/LANDSCAPING	1996	6,811						42
43	CORPORATE OVERHEAD	1997	10,515						43
44	C/R 5/31/99 AUDIT ADJ 1b - CORPORATE OVERHEAD	1997	(10,515)						44
45	PLUMBING/SPRINKLER SYSTEM	1997	2,271						45
46	TILE & INSTALLATION	1997	2,911						46
47	WALLVINYL/PAINTING	1997	12,873						47
48	INSTALL CARPET	1997	1,790						48
49	FRONT ENTRY REMODEL	1997	6,068						49
50	ROOF WORK	1997	1,927						50
51	ELECTRICAL/LIGHTING	1997	10,539						51
52	REPLACE CEILING	1997	22,190						52
53	WALLVINYL/SUITE SIGNS	1997	3,465						53
54	FACILITY PLAN ALLOC.	1997	5,964						54
55	C/R 5/31/99 AUDIT ADJ 1c - FAC. PLAN ALLOC.	1997	(5,964)						55
56	HVAC/EXHAUST SYSTEM	1997	57,390						56
57	BALLUSTERS & TUBES	1997	5,000						57
58	PLUMBING	1997	1,419						58
59	PAINTING	1997	3,782						59
60	ELECTRICAL	1998	6,739						60
61	DOORS & FRAMES/WINDOWS	1998	8,286						61
62	MASONRY WORK	1998	4,000						62
63	DRYWALL/FINISHES	1998	7,000						63
64	WALLVINYL	1998	2,211						64
65	CORPORATE OVERHEAD	1998	1,651						65
66	C/R 5/31/99 AUDIT ADJ 1d - CORPORATE OVERHEAD	1998	(1,651)						66
67	FIRE ALARM INSTALL	1998	20,198						67
68	GENERAL CONTRACTOR FEES	1998	3,000						68
69	INTERIOR DEMOLITION/FLOORING & CEILING	1998	3,390						69
70	TOTAL (lines 4 thru 69)		$ 2,346,912	$ 107,907		$ 107,907	$	$ 2,245,236	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,346,912	$ 107,907		$ 107,907	$	$ 2,245,236	1
2	CARPETING	1998	1,169						2
3	ELECTRICAL/LIGHTING	1998	149						3
4	PAINTING/WALLCOVERING	1998	552						4
5	GENERAL CONTRACTOR FEES	1998	2,507						5
6	SIGNAGE	1998	11,862						6
7	HVAC	1998	3,135						7
8	LANDSCAPING	1998	4,950						8
9	PAINTING/WALLCOVERING	1999	819						9
10	SIGNAGE	1999	1,725						10
11	SECURE CARE SYSTEM	1999	1,278						11
12	COMPRESSOR CHILLER	1999	6,505						12
13	PAGER/SPEAKER SYSTEM	1999	3,900						13
14	NEW DOOR FRAME	1999	1,581						14
15	HOT WATER COMPRESSOR	1999	45,135						15
16	CARPENTRY & ROOFING	2000	148,331						16
17	CARPETING & PADS	2000	12,448						17
18	C/R 5/31/03 AUDIT ADJ #1a - Carpet & Pads	2000	(235)						18
19	WALLCOVERING	2000	48,471						19
20	C/R 5/31/03 AUDIT ADJ #1b - Wallcoverings	2000	(272)						20
21	C/R 5/31/03 AUDIT ADJ #1c - Reclass Equipment	2000	(9,179)						21
22	DEVELOPERS COST - ARCADIA DINING	2000	38,406						22
23	C/R 5/31/03 AUDIT ADJ #1d -Dev. Cost Arcadia Dining	2000	(38,406)						23
24	BORDER	2000	134						24
25	C/R 5/31/03 AUDIT ADJ #1e - Border	2000	(8)						25
26	WALLVINYL - ARCADIA DINING	2000	819						26
27	WALLCOVERING	2000	156						27
28	PAINTING/WALLCOVERING - ARCADIA DINING	2000	3,410						28
29	CARPET	2000	188						29
30	2 A/C UNIT	2001	1,431						30
31	INSTALL SPRINKLER SYSTEM	2001	2,465						31
32	DRAPES	2001	1,520						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,641,859	$ 107,907		$ 107,907	$	$ 2,245,236	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,641,859	$ 107,907		$ 107,907	$	$ 2,245,236	1
2	DOORS	2001	1,056						2
3	FREIGHT ON WALLCOVERINGS	2001	205						3
4	C/R 5/31/03 AUDIT ADJ #1f - Freight on Wallcoverings	2001	(53)						4
5	VWC	2001	5,136						5
6	NEW LANDSCAPING	2001	9,200						6
7	VWC	2001	2,713						7
8	C/R 5/31/03 AUDIT ADJ #2h - VWC	2001	(160)						8
9	INTERIOR - FLOORING & VWC (Audit Adj #2g) Change Yr	2001	20,612						9
10	INTERIOR - FLOORING & VWC (Audit Adj #2g) Change Yr	2002	5,064						10
11	INTERIOR - FLOORING & VWC	2002	20,256						11
12	C/R 5/31/03 AUDIT ADJ #2e - Overhead & Interest	2002	(20,256)						12
13	INTERIOR - FLOORING & VWC	2002	69,157						13
14	C/R 5/31/03 AUDIT ADJ #2f - Interior Flooring & VWC	2002	(206)						14
15	C/R 5/31/03 AUDIT ADJ #2f - Interior Flooring & VWC	2002	(289)						15
16	WALLCOVERING AND BORDER	2002	2,400						16
17	WALL BORDER	2002	89						17
18	VWC	2002	538						18
19	WALL BORDER	2002	28						19
20	INTERIOR - FLOORING & VWC (Audit Adj #2a) Change Yr	2002	24,133						20
21	PLUMBING AND ELECTRICIAL (Audit Adj #2c) Change Yr	2002	8,576						21
22	INTERIOR - FLOORING & VWC (Audit Adj #2b) Change Yr	2002	34,302						22
23	INTERIOR - FLOORING & VWC (Audit Adj #2b) Change Yr	2003	26,714						23
24	C/R 5/31/03 AUDIT ADJ #2b - Interior Flooring & VWC	2003	(450)						24
25	C/R 5/31/03 AUDIT ADJ #2b - Interior Flooring & VWC	2003	(909)						25
26	WINDOW TREATMENTS	2003	1,845						26
27	OVERHEAD & INTEREST	2003	6,809						27
28	C/R 5/31/03 AUDIT ADJ #2j - Overhead & Interest	2003	(6,809)						28
29	OVERHEAD & INTEREST	2003	450						29
30	C/R 5/31/03 AUDIT ADJ #2d - Overhead & Interest	2003	(450)						30
31	RETROADDITION	2003	133						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,851,695	$ 107,907		$ 107,907	$	$ 2,245,236	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,851,695	$ 107,907		$ 107,907	$	$ 2,245,236	1
2	TILE FLOORING	2003	1,946						2
3	FLOORING	2003	2,384						3
4	DOORS	2003	14,965						4
5	FENCE	2003	8,250						5
6	ceramic tile	2004	2,385						6
7	RENOVATION/ 406-01404C	2005	13,607						7
8	PEDIMAT MATTING	2005	1,455						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,686	$ 107,907		$ 107,907	$	$ 2,245,236	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 910,437	$ 78,600	$ 78,600	$		$ 604,542	71
72	Current Year Purchases	100,700						72
73	Fully Depreciated Assets			10,748	10,748			73
74								74
75	TOTALS	$ 1,011,137	$ 78,600	$ 89,348	$ 10,748		$ 604,542	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,936,900	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,507	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 197,255	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,748	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,849,778	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 18,081 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2538	hrs	$ 81,437	2,142	$ 53,561	$ 8,830	4,680	$ 143,828	1
2	Licensed Speech and Language Development Therapist	10a	79	hrs	2,531	1,313	32,830	88	1,392	35,449	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	1320	hrs	42,361	1,153	28,826	7,367	2,473	78,554	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				196,720		196,720	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):	39,3									13
14	TOTAL				$ 126,329	4,608	$ 115,217	$ 213,005	8,545	$ 454,551	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Kankakee # 0027490 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,443	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (44,294))	1,016,762		3
4	Supply Inventory (priced at)	31,016		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,846		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,061,067	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,077		13
14	Buildings, at Historical Cost	2,896,686		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,011,137		16
17	Accumulated Depreciation (book methods)	(2,849,778)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	200,579		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,287,701	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,348,768	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 88,980	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	278,423		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,182		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	64,239		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 500,824	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 500,824	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,847,944	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,348,768	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,352,975	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,352,975	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	404,696	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 404,696	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	90,273	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 90,273	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,847,944	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,655,267	1
2	Discounts and Allowances for all Levels	(570,125)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,085,142	3
	B. Ancillary Revenue		
4	Day Care	2,787	4
5	Other Care for Outpatients		5
6	Therapy	657,246	6
7	Oxygen	(519)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 659,514	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,013	12
13	Barber and Beauty Care	7,346	13
14	Non-Patient Meals	18	14
15	Telephone, Television and Radio	4,534	15
16	Rental of Facility Space		16
17	Sale of Drugs	180,878	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,486	19
20	Radiology and X-Ray	820	20
21	Other Medical Services	2,195	21
22	Laundry	3,868	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 214,158	23
	D. Non-Operating Revenue		
24	Contributions	445	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 445	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,123	28
28a	Late Charges	(13)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,110	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,962,369	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	721,463	31
32	Health Care	2,114,949	32
33	General Administration	1,161,202	33
	B. Capital Expense		
34	Ownership	250,709	34
	C. Ancillary Expense		
35	Special Cost Centers	309,350	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,557,673	40
41	**Income before Income Taxes (line 30 minus line 40)****	404,696	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 404,696	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,996	2,178	$ 67,712	$ 31.09	1
2	Assistant Director of Nursing	3,817	4,164	108,429	26.04	2
3	Registered Nurses	8,659	9,448	230,241	24.37	3
4	Licensed Practical Nurses	21,695	23,671	428,354	18.10	4
5	CNAs & Orderlies	62,112	67,769	710,031	10.48	5
6	CNA Trainees					6
7	Licensed Therapist	2,690	2,987	95,865	32.09	7
8	Rehab/Therapy Aides	1,160	1,288	30,464	23.65	8
9	Activity Director					9
10	Activity Assistants	5,632	6,149	61,716	10.04	10
11	Social Service Workers	3,380	3,684	72,379	19.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,976	18,579	175,994	9.47	15
16	Dishwashers					16
17	Maintenance Workers	1,877	2,046	35,424	17.31	17
18	Housekeepers	8,782	9,595	75,872	7.91	18
19	Laundry	3,898	4,258	38,037	8.93	19
20	Administrator	1,854	2,080	64,315	30.92	20
21	Assistant Administrator	200	200	6,010	30.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,146	8,169	114,807	14.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,812	1,978	21,629	10.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,686	168,243	$ 2,337,279 *	$ 13.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	Monthly	7,700	5,9,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,816	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 11,516		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Lucas	Administrator	0	$ 64,315
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,315

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 272,572
TOTAL (agree to Schedule V, line 17, col. 3)	$ 272,572
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various Vendors	Legal	$ 760
Christine Toolan	Consulting	660
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,469
Unemployment Compensation Insurance	42,825
FICA Taxes	171,649
Employee Health Insurance	182,738
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	5,319
Tuitition Program	935
Employee Uniforms	350
401K	14,784
Other Employee Benefits	518
P/R O/H	(1)
Home Office Allocation	24,711
TOTAL (agree to Schedule V, line 22, col.8)	$ 471,297

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,195
Advertising: Employee Recruitment	13,882
Health Care Worker Background Check	2,562
(Indicate # of checks performed 12)	
Advertising	27,552
Dues & Subscriptions	484
Association Dues	5,178
Less: Lobbying Expense	(1,671)
Less: Public Relations Expense	( )
Non-allowable advertising	(22,782)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,400

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,972
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,972

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Kankakee # 0027490 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Kankakee **#** 0027490 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5,178**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes, $1,671**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,589** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **58,584**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(18)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.